Employee _____ **Employee No.** _____

MARATHON OIL COMPANY
AFFIRMATION FOR ELIGIBLE DEPENDENT(S)
(For Use by Employees)

This form is to verify to the Plan Administrator of the Marathon Oil Company benefit plans that the person(s) listed below meet the qualifications for coverage as dependents under the respective Plans. Please read the definitions carefully as provided in the applicable Plan. TO CHANGE BENEFIT COVERAGE, COMPLETE A BENEFIT CHANGE FORM. Plans and forms can be found at www.MRObenefits.com. By signing, you are attesting that the qualifications are met for every individual listed. The Plan Administrator reserves the right to request documentation for this affirmation at any time.

EFFECTIVE DATE OF CHANGE: _____

SECTION 1 – SPOUSE INFORMATION

I certify that the person listed below is my legal spouse:

Last Name	First Name	MI	Birth Date	Social Security No.	Gender (M/F)
			- -	- -	

If your spouse is a Marathon Oil Company employee, provide their Employee No. _____

To add a Domestic Partner and eligible children of a Domestic Partner, you must complete the Marathon Oil Company Affidavit of Domestic Partner Relationship form, which can be printed from www.MRObenefits.com.

SECTION 2 – CHILD INFORMATION

A child dependent must be under the age of 26. An unmarried disabled child age 26 or older may be eligible; however, an additional form obtained from the Benefits Department must be completed and returned. In addition, the child must be one of the following:

Relationship Codes:

1. A natural child or legally adopted child. **Attach a copy of adoption papers, if applicable.**
2. A stepchild.
3. A child whose natural parents are deceased, who permanently resides with you, and for whom you have legal custody as determined by a court of competent jurisdiction. **Attach a copy of supporting court document(s).**

I certify that the person(s) below meet the eligibility requirements for dependent coverage:

- In the Relationship column, please indicate the Relationship Type as **1, 2 or 3** based on the definitions above. **If you indicate a Relationship Type 1 (adoption) or 3, you must provide the appropriate court document(s) along with this signed form before dependent coverage can be provided.**
- Additional copies of this form should be used if there are more than four eligible children.

Last Name	First Name	MI	Birth Date	Social Security No.[A]	Gender	Relationship (1, 2 or 3)	"X" if Disabled Age 26+
			- -	- -			
			- -	- -			
			- -	- -			

[A] If SSN for a newborn is not available, call or email the Benefits Department when the number is received.

I certify that the information given above is true and correct to the best of my knowledge. I understand that any false statements could result in termination of coverage for me and any dependents. I acknowledge it is my responsibility to notify the Company within 31 days of the date a covered family member no longer qualifies as an eligible dependent.

Signature _____ Date _____

RETURN COMPLETED FORM TO MARATHON OIL COMPANY, ATTN: BENEFITS DEPARTMENT, ROOM 2685, 5555 SAN FELIPE STREET, HOUSTON, TX 77056, FAX TO 713-513-4495, OR SCAN AND EMAIL TO: MROBenefitsHelp@MarathonOil.com. QUESTIONS CALL 1-855-652-3067